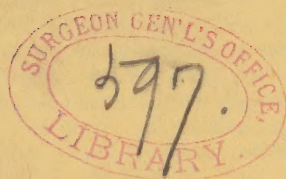


RICHARDSON (M.H.)

A case of pancreatic
cyst * * * * *



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A CASE OF PANCREATIC CYST TREATED BY DRAINAGE; RECOVERY.¹

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N. D., an Italian laborer of twenty-six, I saw at the State Almshouse on November 22, 1894, with Dr. Howard. He had always been well and strong up to his present illness. He first noticed a painless swelling in the pit of the stomach six weeks before operation. This swelling gradually grew larger, and became so painful that he could not sleep at night. There was no interference with digestion or bowels. The appetite was good. The pulse and temperature were normal, the urine contained nothing abnormal. There had been some loss of flesh. The general appearance was poor, and the face cachetic. I found a non-resonant, fluctuating tumor, as large as an adult head, in the epigastrium, a little to the left of the median line. The tumor was so large as to interfere seriously with his comfort, embarrassing respiration and distending tensely the upper half of the abdomen. I made a diagnosis of cyst of the pancreas, from the position of the tumor and from the history of the case. Immediate operation was decided upon; for though the patient's condition was not serious, it clearly indicated the necessity of interference.

A cut was made between the umbilicus and the

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ensiform cartilage. The stomach and transverse colon presented themselves on opening the peritoneum. The omentum having been carefully separated, the tumor was brought into view, and its contents aspirated. "The fluid was viscid and of a dirty-gray color. The reaction was alkaline, and the specific gravity 1.008. There was about one per cent. of albumin, and a considerable amount of mucin. There was a little sediment which showed an occasional fatty degenerated cell. The fluid did not emulsify fat, and had no diastatic action. It had no digestive properties." [Report of Dr. W. F. Whitney.]

About two pints of fluid were withdrawn by aspiration. The parts about the exposed portion of the tumor were then walled off with gauze, and a free opening was made by which about two quarts of fluid escaped. Exploration with the finger showed a large cavity situated in the retro-peritoneal space usually occupied by the tail of the pancreas. The bodies of the lumbar vertebræ could be felt, as well as the pulsations of the abdominal aorta. No stone could be detected.

Separation of the tumor was attempted; but, on getting into the deeper parts, the adherence to the surrounding structures was so intimate, and the blood vessels were so numerous, that no further efforts at enucleation were made. The cyst wall was stitched to the abdominal wound, and a large drainage-tube was inserted. The subsequent history was marked by rapid diminution in the amount of fluid discharged. Three weeks after the operation a specimen was sent to Dr. Whitney which possessed all the characteristics of pancreatic fluid.

In the surgical treatment of pancreatic cysts the important question to be decided is between drainage and radical removal of the sac. In two previous cases reported by the writer, drainage in the manner de-

scribed above proved effectual. In one² the discharge grew gradually less, and the wound became perfectly healed in a few months. A second³ healed perfectly; but a year or two later the cyst reappeared, and proved fatal. A second laparotomy was performed⁴ for symptoms of acute intestinal obstruction due to pressure upon the duodenum by the re-filled sac. At the autopsy a large opening was found between the cyst and the stomach. The cause of death was acute obstruction. A third case, referred to me by Dr. F. C. Shattuck,⁵ though of doubtful pancreatic origin, was cured by complete extirpation of the cyst. The patient, a child of thirteen months, referred to Dr. Shattuck by Dr. Bowers of Clinton, had had a tumor in the abdomen since birth at seven months. The tumor rapidly increased in size, and embarrassed both circulation and respiration. The whole abdomen was filled by a fluctuating tumor, apparently arising from the left, supposed to be a hydronephrosis. The tumor was dissected from its attachments back of the peritoneum in the pancreatic space. There were numerous large vessels supplying it, and it was crossed by the splenic vein. The tail of the pancreas was spread out over the anterior wall of the tumor. Seven pounds of fluid were removed. Drs. Fitz and Whitney reported the tumor to be of retro-peritoneal origin, and congenital. More detailed examination showed true pancreatic tissue in the cyst wall. My own observations convinced me that the pancreas was involved only by pressure from behind. The child made a good recovery, and has grown up into a very robust boy. In this case enucleation was rapid and easy.

² Boston Medical and Surgical Journal, January, 1892, p. 86.

³ Ibid., January, 1891, p. 111.

⁴ Ibid., May, 1892, p. 441.

⁵ Published in the Transactions of the American Surgical Association for 1892, p. 211.

By avoiding the splenic vein and by tying the pedicle *en masse*, no hemorrhage ensued.

In the fourth case, reported above, attempts were made to remove entirely the cyst wall. The difficulties met with early in the attempt led to its abandonment, and the usual practice among those who have operated for this condition was followed.

Recently a case has been reported ⁶ in which the whole cyst was successfully enucleated. That such a method is preferable, if safe, is doubtless true. Yet if the cyst is a dilatation of the canal of Wirsung, it is evident from the excessive discharges during the first few days after drainage that the digestive processes will lose permanently a large amount of pancreatic fluid by the method of total extirpation. Numerous observations show that complete healing takes place after drainage in most cases, and that the danger from this method of treatment is slight. It seems, therefore, well to follow this method generally. If the cyst can be easily separated from its attachments and thoroughly extirpated without excessive hemorrhage, it seems best to attempt such a procedure, in view of the possible re-accumulation of fluid, with its remote dangers, as in the second case cited. The attempt at enucleation should be abandoned, however, as soon as it is evident that the cyst is so thoroughly incorporated with the surrounding pancreatic tissues that it can be separated only by cutting.

In the case reported above the diminution of discharge has been rapid, and the general improvement has been marked. Nine weeks after operation I found the cavity of the cyst obliterated, nothing remaining but a sinus through which a probe could be passed nearly to the bodies of the lumbar vertebræ.

⁶ Sharkey and Clutton : St. Thomas Hospital Reports, xxi, p. 271, 1893.

